DEPARTMENT OF HEALTH

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ESTATECODE

GUIDANCE ON THE

ESTATE ACTION PLAN

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ESTATE ACTION PLAN

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DEPARTMENT OF HEALTH

Advisory Group on Estate Management

Part of
ESTATECODE
Level 2

Guidance on the

ESTATE ACTION PLAN

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This Guidance is issued by the Advisory Group on Estate Management. Any enquiries on it should be made to the AGEM Secretariat, Estate and Property Management Directorate, Euston Tower, 286 Euston Road, London NW1 3DN

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1. *The Corporate Accountability of Managers for Action on the NHS Estate*

1.1 Successful estate management in its broadest sense is very difficult to achieve in an organisation as complex as the NHS. It needs to be carried through competently in all aspects of the repetitive cycles which must progress through the successive stages of preparing planning options, taking the decisions, implementing the changes, maintaining operational control throughout and, with the benefit of subsequent learning, returning once again to planning. Through all of these stages General Managers, estate management professionals, specialist planners and members of the many caring professions have to find effective, timely and economical ways to work together.

1.2 General Managers have had many new responsibilities thrust upon them since HC(86)13. One area in which this clearly applies is in the management of all NHS technical and property assets. Thus far, the significance and scale of the General Manager's accountability for capital resources, when these are considered as the essential environmental components in service delivery, have yet to receive their due emphasis. The following pages clarify the interdependence of estate and service planning and attempt to fill this gap.

1.3 The Griffiths Inquiry Team's report, which was accepted by Ministers, introduced a new focus when it stressed the importance of the property function, in the general and not the functional management sense, and emphasised that the estate must be commercially exploited and be regarded as an active contributor to overall NHS resources. The Davies Committee report had similarly described ways in which an enhanced contribution to healthcare could be achieved locally by more imaginative and skilled property management. There have been many achievements already, as the growing yields from the sales of surplus lands demonstrate, but much more remains to be done.

1.4 The Estate Action Plan draws upon wide experience in the field. It documents the steps through which successes have been achieved on both large and small scales; but an essential prerequisite for success is that the planning and management of the estate have to be fully integrated within the continuing "management of the whole". This is perhaps most necessary where it currently occurs least frequently, that is in the early conceptual stages of planning, when broad brush options for a region, for a whole district, for units, or for fully integrated community and hospital services are being explored.

1.5 The Estate Action Plan is no different from other plans in that it is a selection from what seems to be the best of the current options; but learning will be gained from its use and in due course it will itself be updated. It sets out one proven way of implementing this complex process effectively.

2. *The Respective Roles of General Managers and Estate Managers*

2.1 Tasks that are everyone's responsibility can all too easily become those that are actually undertaken by nobody. This can be a problem in establishing fully effective estate management because almost all of the senior staff in any district will at times have to play a significant role, however briefly, in one or more of the cyclical stages described earlier. Success in using the Estate Action Plan inevitably depends, therefore, upon the clear designation within each Health Authority of who is expected to do what, and when. Although the previous section emphasised the need to integrate all contributions into one corporately effective whole, the General Manager must also allocate individual managerial accountability for each of the parts.

2.2 A Health Authority is, of course, entitled to hold its General Manager ultimately accountable for the proper management of all of its directly provided services. A significant part of these services is the planning and use of buildings, land and plant. These must be integrated with other resources such as manpower and finance. All of these major resources have to be marshalled in such a way that they can contribute optimally to the overall achievement of the Authority's service objectives. An optimal contribution will often mean that service overheads are being minimised.

2.3 The personal contributions of General Managers to estate management will usually be greatest in the planning stages and in the negotiation of how the Health Authority's property management as a whole will influence or be affected by the wider society, both within and beyond the NHS. In consequence, General Managers will often be involved in discussions between units, districts, regions and the Department about relative priorities and about the requisite directions to maximise progress. Furthermore, they may also play significant roles in negotiations with local authorities, housing associations, voluntary groups, and so on. Within the Estate Action Plan their roles will therefore frequently be concerned with activities which span organisational boundaries.

2.4 In addition, the General Manager has to ensure personally that the estate action planning sequence, and its regular revisions

thereafter, are driven through powerfully each time. Coordinating this process is a task that should not be underestimated. In consequence the General Manager will usually delegate much of this work although remaining accountable for the actual rate of progress, and the quality of the final plan produced. The person responsible for managing these core components of the Estate Action Plan will be determined locally but the work must be done either by, or in close collaboration with, the Estate Manager (although the job titles for this role vary across districts).

3. *The Stages of the Estate Action Plan*

Stage 1. *Estate Data Base*

3.1 The estate is one of the key NHS resources and as such the effectiveness of its management will affect the delivery of healthcare. The management of the NHS estate should be both cost effective and responsive to the needs of the patient service. Management is the blending of available resources, taking into consideration the myriad constraints, to attain a corporate strategy. Authorities need a comprehensive and consistent set of estate information on which to base their decisions.

3.2 The Advisory Group on Estate Management has recommended that a District Minimum Data Set for the estate should be held at all Districts.

3.3 The estate management function has three related activities:

i strategic estate planning which interacts with service planning, and includes the acquisition and disposal of property;

ii the management of the estate and its assets;

iii the planning, design and provision of new or upgraded buildings, plant, services and equipment.

In defining the District Minimum Data Set particular attention was given to:

i the currency of data (ie how long a piece of information was valid);

ii the ease of collection;

iii cost of collection;

iv its use by estate managers, by others at District and the need for it outside the District;

v its availability elsewhere;

vi the validity of the data at the time of collection.

Managers should not be constrained by the Minimum Data Set. Their day-to-day maintenance and operational requirements by way of local management structures, practical considerations or individual styles, may demand a wider information base.

3.4 The information contained within the Minimum Data Set will, with the appropriate analysis, be sufficient to plan and manage the estate so that it is capable of sustaining a maximum delivery of healthcare. In particular information is required to:

i monitor the effectiveness of expended resources;

ii rationalise the estate so that it meets both current needs, and future ones, identified in the Strategic Plan;

iii carry out meaningful option appraisals and prepare budgets;

iv plan and control the programme of capital programme expenditure, replacements and upgradings embodied in the Estate Control Plan;

v identify the cost of the estate management function.

Stage 2. *Estate Performance Analysis*

3.5 Two levels of estate performance indicators have been devised to assist in improving local estate management. In practice, the first line indicators are used as an overall guide to performance, whilst the second line indicators, of which there are about 50, are designed to assist District management. These indicators relate to the amount of property held, the amount spent on maintenance, energy usage, staff numbers, and the condition of the estate.

3.6 The first line indicators are:

i number of hectares per 1000 of population;

ii percentage of land held which is considered to be surplus to requirements;

iii building area per bed;

iv building area per 1000 of population;

v amount required to bring the built estate up to an acceptable standard (Condition B);

vi maintenance expenditure;

vii energy used;

viii number of PTB staff employed;

ix number of direct labour staff employed;

x relationship between the area of land held and the floor area of the buildings on it;

xi physical condition profile.

The indicators enable comparisons to be made between the performance of different estates, both within and outside the service, and also indicate where improvement may be possible. Authorities should pay particular attention to their physical condition profile and estate expenditure including maintenance, energy and capital. This in turn will be reinforced by the introduction of capital asset accounting initiatives. Returns should be made annually.

Stage 3. *Estate Rationalisation*

3.7 A structured approach to planning the interaction of need and the rationalisation of the three major resources (manpower, finance and the estate) has been devised and given the shorthand description of the "Mereworth" method. The application of this approach will create a District profile which, together with the defined service needs, will be used to indicate, in broad terms, the direction along which the estate is to be developed and the options which are available.

3.8 There is a need to reduce the estate to an optimum size but that size and extent can only be identified when other service factors have been taken into account. Districts will find that as well as providing additional capital funds, revenue savings can be identified which can be re-invested in direct patient care or on improving the estate. Decisions on what property to dispose of, how much money to be invested in building new stock or maintaining the existing estate, should not be agreed until this exercise has been completed together with Stage 4.

Stage 4. *Evaluation of Alternative Estate Strategies*

3.9 The evaluation will involve Authorities in option appraisal studies as an integral part of strategic services and capital investment appraisals and in reviewing and developing estate management plans which will form the basis for an Estate Control Plan for the strategic planning period and beyond.

3.10 An appraisal will be essential because:

i there are likely to be several different possible ways in which the estate can be rationalised or services provided in order to achieve an optimum which will satisfy the planned objective for healthcare;

ii each of these alternatives, including other ways of delivering the service, will be the subject of an option appraisal which takes into account not only the total resource implications, but the effect on the delivery of care during the period of change;

iii each alternative will need to be formulated on the basis of known short term resource assumptions, and anticipated long term assumptions;

iv the options will take the form of investment plans with the preferred option being included in the Investment Programme.

The elements to be considered are:

1. Does it conform to national policy?
2. Does it conform to Region/District strategy for Healthcare Group?
3. Does it conform to overall site strategy?
4. Is the plan flexible?
5. What is the whole life cost?

Stage 5. *Estate Investment Programme*

3.11 The Investment Programme will form part of the overall strategic plan for the Authority. It will be presented in the form of

a balance sheet showing the expected investment on the estate and the anticipated returns and benefits.

3.12 These returns will be:

i improvement in patient service;

ii income from disposals;

iii revenue savings arising from estate rationalisation and more effective use of property.

The annual programmes will be arranged in care groups and benefits can be related to service provision.

3.13 The Table below identifies elements that need to be included.

Elements included in Estate Investment Programme	
Investment	Return on Investment
Finance	Receipts from sales
—Capital —Revenue	Reduced expenditure arising from rationalisation or improved utilisation
—Brokerage	Improvements in patient service
—Land Sales	Improved property performance
Manpower	

3.14 Included within the Estate Investment Programme will be major and minor schemes ranging from the construction of a new hospital down to relatively low cost ward up-gradings. The revenue consequences of these schemes will be included where there are no changes envisaged.

3.15 It is at this stage that the funding Authorities will have to adjudicate between, and arrange priority for, bids for investment/expenditure. This process is the culmination of all the planning exercises described earlier. Clearly, emphasis should be given to revenue and capital saving schemes in the earlier years of the Estate Investment Programme. This will usually result in greater service rewards in the latter stages and will provide the 'enabling' monies early on in the Programme.

3.16 It is important to identify the necessary funding for each scheme and to ensure that the funding is included in the programme for the appropriate date.

3.17 As with any long term plan, the Estate Investment Programme needs to be effectively monitored not only to confirm that it is being achieved, but also to ensure that amendments are made as and when they become necessary. In this way alterations to the original plan do not just happen but are properly planned in as part of the overall revised strategy.

Stage 6. *Estate Control Plan*

3.18 The Estate Control Plan will encapsulate in one document all the key decisions reached during the previous five stages. Thus, the plan will show the estate as it exists and as it is intended to be at the end of the strategic plan period. Included in the plan will be both the resources available and the contribution towards those resources which will be derived from rationalisation.

3.19 The Estate Control Plan must be a document to which the Authority is committed, it must also be capable of adaptation to meet changing needs.

3.20 The Estate Control Plan will be in two main parts, namely:

i a plan for a District;

ii a plan for each site whether or not change is expected including sites planned to be closed or those which are within a green belt or conservation area or which contain listed buildings and which may require carefully planned run down.

The District Plan will comprise a map supported by text.

The map will show:

i the location of healthcare premises;

ii the main communication routes;

iii Local Authority and Health Authority boundaries;

iv major Local Authority social service facilities.

The text will comprise:

i a brief description of the District and of the changes intended in the means of the delivery of healthcare by the Health Service, Local Authority, or other outside sources;

ii the Site Estate Investment Programme.

3.21 A site control plan will also comprise a plan and a supporting text setting out the implications for the property following up decisions taken in the earlier stages.

3.22 The plan should be based on Ordnance Survey 1/1250 scale plans, though it is recognised that these may need to be reduced in size if they are to be included in a bound document. The map attached to the Estate Terrier may be suitable.

It will show:

i the site boundary as existing;

ii easements and restrictions;

iii land to be sold;

iv land to be acquired;

v buildings to be demolished;

vi buildings to be upgraded;

vii proposed new buildings;

viii proposed changes of use;

ix listed buildings;

x property surrounding the hospital and its existing and proposed use;

xi proposed roadworks which may affect the hospital;

xii routes of public utilities/routes of main services;

xiii the results of condition appraisal, space utilisation, functional suitability, energy, and statutory compliance surveys.

The supporting text will comprise:

i a brief description of the site and the proposed changes;

ii a summary of proposed schemes with dates and costs.

3.23 The closure and disposal of a hospital, especially if it lies within a green belt or contains listed buildings, calls for special attention. The guidelines in DOE Circular 12/87 should be adhered to and early discussions sought with the Planning Authority.

3.24 A much more pressing problem, however, is the requirement to maintain an acceptable standard of care during the run-down period whilst at the same time providing funds for the alternative. This is especially apparent in the changing attitudes towards services for the mentally handicapped and both the District and Site Control Plans must take account of this.

Stage 7. *Estate Operational Plan*

3.25 The Estate Operational Plan will be compatible with, and form part of, the annual plan for each individual site. It describes the proposals for the estate and monitors progress towards the targets set in the Estate Control Plan and Investment Programme. Use of WIMS will facilitate the proper management and manipulation of estate information.

3.26 The Operational Plan will be on-going with a firm target for year one and more tentative targets for ensuing years. At the end of year one, achievement will be measured against the target and the plan for the next year will be amended to recognise both shortfall and any amendments to the healthcare programme.

3.27 An Estate Operational Plan will comprise six major elements:

i the compilation of an asset register;

ii rationalisation of assets owned following on from the definition of service need;

iii rationalisation of assets — mini "Mereworth" — resulting in the selection of an approved plan;

iv the management of assets which explores all ways in which maintenance and operations can be carried out more effectively;

v implementation of the plan;

vi feedback.

3.28 An asset is basically an item of equipment or property with a capital value of £1,000 or more.

In order that assets can be effectively managed it is essential to have a register which identifies them, their age, condition, function, and the person responsible for the function.

3.29 Asset management has four inter-related aims:

i to safeguard the long term interests of assets;

ii to assess the importance of the asset and associated life risk implications, and to fulfil the statutory and safety requirements associated with an asset;

iii to meet the user's requirements and expectations and to ensure that spare capacity and utilisation are considered;

iv to formulate a policy for the maintenance of an asset and its ultimate replacement or disposal.

3.30 To meet these aims the Estate Operational Plan should take into account the following points:

i in order to safeguard the long term interests, and to obtain the best value from it, the asset must be maintained at optimum level compatible with its expected life, even if this appears to conflict with a user's short term objections to the expenditure of money for maintenance (to persuade a user to accept this point, the effect on patient service of not maintaining the asset should be considered and priority should be given on that basis);

ii all assets must be maintained so as to fulfil their function, conform to statutory and safety requirements, and the necessary resources must be identified within the Operational Plan;

iii the requirement to meet the user's needs has been discussed above, but it must be recognised that as well as his own needs the user may be required to consider ambitions and objectives of others and these must be taken into account;

iv assets have a finite life and provision must be made for replacement on a planned, rather than an ad hoc, basis; and where assets are expected to become surplus to requirements, maintenance should be geared to ensure that whilst only the minimum resources are expended to keep the asset safe and functional and to retain the disposal value.

3.31 The selection of the approved Operational Plan will result from a combination of the targets identified within the Strategic Plan, the schemes identified in the Estate Control Plan, and the asset management or maintenance programme.

3.32 Implementation of the Plan will lie mainly with the Estates Manager, though it must be recognised that estate management is a function of healthcare and cannot be carried out in isolation.

3.33 Feedback will be continuous from day one of the Plan and will keep all levels of management aware of both progress and problems. It will be necessary, however, to carry out an annual healthcare plan in order to redefine objectives in the light of experience or changed circumstances.

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